

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: THE PALLADIUM FOR SURGERY DALLAS, LTD 5920 FOREST PARK ROAD #700 DALLAS, TX 75235	MFDR Tracking #: M4-09-9795-01
Respondent Name and Box #: LIBERTY MUTUAL INSURANCE CORP. Rep Box # 28	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Billed timely and pmt is due."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - \$862.79
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "CPT 64475 SG 50 was denied as exceeds the number of billable units. Per Medicare Guidelines, bilateral procedures are billed as one unit with a 50 modifier. Provider billed as two units."

CPT 62311 denied as not documented in op report as performed. Also this procedure was not preauthorized.

CPT 64476 SG 50 was denied as exceeds billable units. Per Medicare Guidelines, bilateral procedures are billed as one unit with a 50 modifier. Provider billed as two units."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/17/08	64475-SG-50 (2 UNITS)	17, 42, W1, Z710, U899, U849	1-4	\$3.14
10/17/08	64476-SG-50 (2 UNITS)		1-3, 5	\$350.34
10/17/08	62311-SG	B12, X129	1, 2, 6	\$0.00
Total /Due:				\$353.48

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATIONTexas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:
 - “17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate;
 - 42-Charges exceed our fee schedule or maximum allowable amount;
 - W1-Workers Compensation Fee Schedule Adjustment;
 - Z710-The charge for this procedure exceeds the fee schedule allowance;
 - U849-This multiple procedure was reduced 50%% according to fee schedule or usual and customary guidelines;
 - U899-Procedure has exceed the maximum allowed units of service;
 - X129-Procedure not documented in operative report; and
 - B12-Services not documented in patients’ medical records.”

2. The 10/17/08 operative report indicates the claimant underwent the following:

- “Bilateral lumbar facet injection at L4-L5 and L5-S1.”

The Requestor supported billing of CPT code 64475-SG-50 and 64476-SG-50 performed bilaterally. The documentation does not support two units of 64475-SG-50 or two units of 64476-SG-50; therefore, the insurance carrier’s denial of “17” is supported.

3. Per the descriptor CPT code 64476 is to be used in conjunction with CPT code 64475 to designate injections to additional levels of the lumbar spine. In addition, when bilateral injections are performed the -50 modifier should be added to the code. Also, that code 64476 ...”as it is an add-on code and exempt from the multiple procedure concept.” The Requestor billed CPT code 64476-SG-50 for bilateral facet joint injections to L5-S1.
4. Per Rule 134.402(f) reimbursement for non-device intensive procedure for CPT code 64475-SG-50 is:

The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = \$449.34.
The national reimbursement is divided by 2 = \$224.67 (\$449.34/2).

This number X City Conversion Factor/CMS Wage Index for Dallas $224.67 \times 0.9915 = \$222.76$.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $224.67 + \$222.76 = \447.43 .

This number multiplied by 150% for bilateral procedure $447.43 \times 150\% = \$671.15$.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $671.15 \times 235\% = \$1,577.20$.

The MAR for CPT code 64475-SG-50 is \$1,577.20. The insurance carrier paid \$1,025.17. The difference between amount due and paid equals \$552.03. The Requestor is seeking \$3.14, this amount is recommended.

5. Per Rule 134.402(f) reimbursement for non-device intensive procedure for CPT code 64476-SG-50 is:

The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = \$147.85.
The national reimbursement is divided by 2 = \$73.93 (\$147.85/2).

This number X City Conversion Factor/CMS Wage Index for Dallas $73.93 \times 0.9915 = \$73.30$.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $73.93 + \$73.30 = \147.23 .

This number multiplied by 150% for bilateral procedure $147.23 \times 150\% = \$220.85$.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $220.85 \times 235\% = \$519.00$.

The MAR for CPT code 64476-SG-50 is \$519.00. The insurance carrier paid \$168.66. The difference between amount due and paid equals \$350.34, this amount is recommended for reimbursement.

6. On this date, the Requestor also billed CPT code 62311 –“Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal).” The Respondent denied reimbursement based upon the procedure not being documented in the operative report. A review of the operative report does not document or support billing of CPT code 62311; therefore, no reimbursement is recommended.

The Respondent noted in their response that preauthorization was not obtained for this service. Since this issue was not raised prior to the Requestor seeking medical dispute resolution it will not be considered in this decision per Rule 133.307(d)(2)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **\$353.48** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

8/25/09

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.